DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED			
		445502	B. WING		ı	08/11/2020			
NAME OF PROVIDER OR SUPPLIER THE WATERS OF SMYRNA, LLC				STREET ADDRESS, CITY, STATE, ZIP 202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167	STREET ADDRESS, CITY, STATE, ZIP CODE 202 ENON SPRINGS ROAD EAST				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			BE COMPLÉTION			
F 000	was conducted by the 2020 at The Waters found to be in comparted in fection control registre CMS and Center Prevention (CDC) in prepare for COVID-	sed Infection Control Survey the State Agency on August 11, s of Smyrna. The facility was bliance with 42 CFR §483.80 gulations and has implemented ers for Disease Control and ecommended practices to -19. Total census was 77.		TITLE			(X6) DATE		

Facility ID: TN7509

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		445502	B. WING			08/11/2020	
NAME OF PROVIDER OR SUPPLIER THE WATERS OF SMYRNA, LLC				STREET ADDRESS, CITY, STATE, ZIP C 202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167	ODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	IX (EACH CORRECTIVE ACTION	SHOULD	BE	(X5) COMPLETION DATE
E 000	Survey was conduct August 11, 2020. TI	sed Emergency Preparedness sted by the State Agency on the facility was found to be in CFR §483.73 related to	E	DEFICIENCY)			
1000173	A DIDECTORIO OD 2001/20	ER/SLIPPLIER REPRESENTATIVE'S SIGN	IATLIDE	TITLE			(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION		COMPLETED	
	TN7509 B. WING			08/11/2020			
NAME OF PROVIDER OR SUPPLIER THE WATERS OF SMYRNA, LLC STREET ADDRESS, CITY, STATE, ZIP CODE 202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
N 000	was conducted by t 11, 2020. The facilit compliance under 0 for Nursing Homes, and has implement Control and Preven	ed Infection Control Survey the State Agency on August ty was found to be in Chapter 1200-8-6, Standards, infection control regulations ed the Centers for Disease tion (CDC) recommended to for COVID-19. Total	N 000				

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

4QFP11